Rec'd 6/27/06

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

June 26, 2006

Betty Gould
Regulations Officer
Division of Regulatory Affairs,
Records Access, and Policy Liaison
Indian Health Services
Attn: CMS-2206-P
801 Thompson Avenue, Suite 450
Rockville, MD 20852

RE: Prescription Drug, Improvement, and Modernization Act of 2003 – Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Indians.

Dear Ms. Gould:

MHA, An Association of Montana Health Care Providers, on behalf of its 55 hospital members, including 5 IHS Service Units located in Montana, appreciates the opportunity to comment on the above referenced regulations. The proposed regulations specify that Montana hospitals, and critical access hospitals, must accept Medicare-like payment rates for services authorized by IHS. MHA is concerned that the regulations, as proposed, create a significant risk for facilities that furnish substantial amounts of care to Native Americans. The regulations also pose at least some risk for loss of access to care if financial problems related to these policies materialize in the future.

Section 506 of the Medicare Modernization Act authorizes CMS to establish "Medicare-like" payment rates for IHS funded health care. It appears that the Department is adopting an approach with minimal effort imposed on the government, but one which could have significant impacts on the hospital community. MHA is concerned about the method to determine the payment rate for medical services, claims processing procedures and the impact that this regulation may have on existing contracts, PPO arrangements and other agreements.

The proposed regulation states that IHS will make payments "consistent with the methodology to determine interim rates payments in accordance with 42 CFR part 413, subpart E." Further, the actual amount will be "consistent with CMS instructions to its fiscal intermediaries at the time the claim is processed." We do not understand how IHS expects the I/T/U intermediary to determine the appropriate price. Does the Department intend to require the I/T/U intermediary to install various grouper and other PPS software products to make payments based upon DRG, APC and RUGS methods? Since the

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Medicare FI does not receive the claim for IHS services how will the FI advise the I/T/U intermediary about the proper price to pay for a service?

A great deal of IHS-funded primary care is provided at small, rural hospitals located on or adjacent to reservation lands. The hospitals in this circumstance in Montana are all licensed as critical access hospitals. CAHs are paid by Medicare at 101% of reasonable costs. It will be a simple task for the I/T/U intermediary to collect interim rate data for pricing critical access hospital services. But rates for CAHs are adjusted from time to time, and not always based upon cost report periods. How will IHS keep track of the various rate changes?

We also question whether the IHS is, by reference to the Medicare regulations, incorporating CAH Method II billing policies, and other special payment rules for CAHs. .

Montana's tertiary hospitals provide both primary care and specialty services. These services are sometimes governed by contracts with IHS, whereby pricing considerations are part of preferred provider arrangements. The regulation specifies that IHS will rely upon current FI rate information. The proposed regulations are unclear about how IHS will determine the appropriate DRG, RUG or other prospectively determined price will apply to the service.

IHS explains in its proposed regulations that hospitals are free to negotiate contracts for less than Medicare payments, but existing contracts may not pay more than Medicare amounts. MHA believes that the Department should expect that many hospitals will opt to cancel their contracts with IHS, especially if the contracts provide lower than Medicare pricing. If the existing contract calls for payments that exceed Medicare rates the contract is likely nullified by the regulation since a major portion of the contract is no longer valid.

Some of these same facilities hold contracts with IHS or tribes who operate their health services under compact agreements.

MHA is very concerned that the proposed regulation authorizes HIS-funded care furnished at critical access hospitals to be paid at interim percentage of charge or per diem payment rates. There is no requirement to follow Medicare policy for settlement of underpayments based upon a Medicare cost report. When adopting "Medicare-like" rates it seems that the IHS plan should include the key features of the Medicare payment methods. For CAHs and provider-based rural health clinics, the cost settlement process is a very key feature.

For this reason, MHA opposes adoption of the proposed regulation. Cost settlement for small critical access hospitals is an extremely important step to assure adequate payments are made for furnishing health services. CAHs are typically low-volume service providers, heavily dependent on Medicare and other public programs. Those CAHS located on or near reservation lands are

also dependent, in part, on payments for IHS-funded care. MHA notes that the IHS concluded that IHS-funded care is typically only 2% of provider revenues. While this number may be a reasonable average, some hospitals derive much more of their revenue from IHS.

To address this problem MHA recommends that IHS include a provision for a CAH to request, and receive, a cost settlement for significant amounts of funding. A significant amount could be expressed as a percent of the unpaid cost, a dollar threshold or some other combination of factors.

Medicare Fiscal Intermediaries attempt to establish interim payment rates that avoid large payment adjustments at the end of each cost report cycle. But small hospitals can experience relatively large changes in revenue due to small changes in service volume. Thus, a cost settlement process is a crucial step to avoid being underpaid for services. It is not a true statement that overpayments are offset by underpayments, and the issue is a financial wash.

Please contact me if you require additional information or wish to discuss this letter in greater detail. I can be reached at 406-442-1911 or by email at Bob@mtha.org.

Sincerely,

Robert W. Olsen
Vice President